256.969 INPATIENT HOSPITALS

Subdivision 1. **Annual cost index.** The commissioner of human services shall develop a prospective payment system for inpatient hospital service under the medical assistance and general assistance medical care programs. Rates established for licensed hospitals for rate years beginning during the fiscal biennium ending June 30, 1987 shall not exceed an annual hospital cost index for the final rate allowed to the hospital for the preceding year not to exceed five percent in any event. The annual hospital cost index shall be obtained from an independent source representing a statewide average of inflation estimates determined for expense categories to include salaries, employee benefits, medical fees, raw food, medical supplies, pharmaceuticals, utilities, repairs and maintenance, insurance other than malpractice insurance, and other applicable expenses as determined by the commissioner. The index shall reflect the regional differences within the state and include a one percent increase to reflect changes in technology. The annual hospital cost index shall be published 30 days before the start of each calendar quarter and shall be applicable to all hospitals whose fiscal years start on or during the calendar quarter.

Subd. 2. **Rates for inpatient hospitals.** On July 1, 1984, the commissioner shall begin to utilize to the extent possible existing classification systems, including Medicare. The commissioner may incorporate the grouping of hospitals with similar characteristics for uniform rates upon the development and implementation of the diagnostic classification system. Prior to implementation of the diagnostic classification system, the commissioner shall report the proposed grouping of hospitals to the senate health and human services committee and the house health and welfare committee. The computation of the base year cost per admission and the computation of the relative values of the diagnostic categories must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs and days beyond that point. Claims paid for care provided on or after August 1, 1985, shall be adjusted to reflect a recomputation of rates, unless disapproved by the federal Health Care Financing Administration. The state shall pay the state share of the adjustment for care provided on or after August 1, 1985, up to and including June 30, 1987, whether or not the adjustment is approved by the federal Health Care Financing Administration. The commissioner may reconstitute the diagnostic categories to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register and a 30-day comment period. After May 1, 1986, acute care hospital billings under the medical assistance and general assistance medical care programs must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments with inpatient hospitals that have individual patient lengths of stay in excess of 30 days regardless of diagnosis-related group. For

purposes of establishing interim rates, the commissioner is exempt from the requirements of chapter 14. Medical assistance and general assistance medical care reimbursement for treatment of mental illness shall be reimbursed based upon diagnosis classifications. The commissioner may selectively contract with hospitals for services within the diagnostic classifications relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to utilize a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital. Effective July 1, 1988, the commissioner shall limit the annual increase in pass-through cost payments for depreciation, rents and leases, and interest expense to the annual growth in the hospital cost index described in subdivision 1. When computing budgeted pass-through cost payments, the commissioner shall use the annual increase in the hospital cost index forecasted by Data Resources, Inc. consistent with the quarter of the hospital's fiscal year end. In final settlement of pass-through cost payments, the commissioner shall use the hospital cost index for the month in which the hospital's fiscal year ends compared to the same month one year earlier.

Subd. 2a. **Audit adjustments to inpatient hospital rates.** Inpatient hospital rates established under subdivision 2 using 1981 historical medicare cost-report data may be adjusted based on the findings of audits of hospital billings and patient records performed by the commissioner that identify billings for services that were not delivered or never ordered. The audit findings may be based on a statistically valid sample of billings of the hospital. After the audits are complete, the commissioner shall adjust rates paid in subsequent years to reflect the audit findings and recover payments in excess of the adjusted rates or reimburse hospitals when audit findings indicate that under payments were made to the hospital.

Subd. 3. **Special considerations.**

(a) In determining the rate the commissioner of human services will take into consideration whether the following circumstances exist:

(1) minimal medical assistance and general assistance medical care utilization;

(2) unusual length of stay experience; and

(3) disproportionate numbers of low-income patients served.

(b) To the extent of available appropriations, the commissioner shall provide supplemental grants directly to a hospital described in section 256B.031, subdivision 10, paragraph (a), that receives medical assistance payments through a county-managed health plan that serves only residents of the county. The payments must be designed to compensate for actuarially demonstrated higher health care costs within the county, for the population served by the plan, that are not reflected in the plan's rates under section 256B.031, subdivision 4.

(c) The computation of each hospital's payment rate and the relative values of the diagnostic categories are not subject to the routine service cost limitation imposed under the Medicare Program.

(d) Indian health service facilities are exempt from the rate establishment methods required by this section and section 256D.03, subdivision 4, and shall be reimbursed at the facility's usual and customary charges to the general public.

(e) Out-of-state hospitals that are located within a Minnesota local trade area shall have rates established using the same procedures and methods that apply to Minnesota hospitals. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this paragraph until required by rule and hospitals affected by this paragraph shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This paragraph is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this paragraph at least 90 days before the start of the hospital's fiscal year.

(f) Hospitals that are not located within Minnesota or a Minnesota local trade area shall have rates established as provided in paragraph (e) or, at the commissioner's discretion, at an amount negotiated by the commissioner. Relative values shall not be affected by negotiated rates.

(g) For inpatient hospital originally paid admissions, excluding Medicare cross-overs, provided from July 1, 1988 through June 30, 1989, hospitals with 100 or fewer medical assistance annualized paid admissions, excluding Medicare cross-overs, that were paid by March 1, 1988, for admissions paid during the period January 1, 1987 to June 30, 1987, shall have medical assistance inpatient payments increased 30 percent. Hospitals with more than 100 but fewer that 250 medical assistance annualized paid admissions, excluding Medicare cross-overs, that were paid by March 1, 1988, for admissions paid during the period January 1, 1987 to June 30, 1987 shall have medical assistance inpatient payments increased 20 percent for inpatient hospital originally paid admissions, excluding Medicare cross-overs, provided from July 1, 1988 through June 30, 1989. This provision applies only to hospitals that have 100 or fewer licensed beds on March 1, 1988.

Subd. 4. **Appeals board.** An appeals board shall be established for purposes of hearing reports for changes in the rate per admission. The appeals board shall consist of two public representatives, two representatives of the hospital industry, and one representative of the business or consumer community. The appeals board shall advise the commissioner on adjustments to hospital rates under this section.

Subd. 5. **Appeal rights.** Nothing in this section supersedes the contested case provisions of chapter 14, lthe administrative procedures act.

Subd. 6. **Rules.** The commissioner of human services shall promulgate emergency and permanent rules to implement a system of perspective payment for inpatient hospital services pursuant to chapter 14, the administrative procedure act. Notwithstanding section 14.53, emergency rule authority authorized by Laws 1983, chapter 312, article 5, section 9, subdivision 6, shall extend to August 1, 1985.